**NORTH STAR FAMILY MEDICINE, P.A.**

**7215 Wyoming Springs Drive**

**Building 3, Suite 700**

**Round Rock, TX 78681**

**(512) 246-3344**

**PATIENT DEMOGRAPHICS**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M OR F

Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single / Married / Separated/ Divorced / Widowed/Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race (please circle): White / African American / Asian / American Indian/Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Drivers License Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employers Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Physician(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Most convenient means of communication of appointments, lab results and general information :

Primary Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Secondary Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\* Please give insurance card to receptionist to make a copy** \*\*

**If we are unable to reach you due to incorrect phone numbers, your appointment may be cancelled**.

**MINOR PATIENTS - please provide a parent or guardian's Name and Social Security Number**

**Parent/Guardian (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please be advised that our Privacy Policy is posted in our waiting room for you to review. Should you have any questions concerning this policy, please inquire at the front desk**.

**North Star Family Medicine, P.A.**

**Patient Information- Revised 1/1/2024**

Due to many changes in healthcare and our ability to comply with those changes and the growth in our practice, we have designed the following policies and procedures for our office. This handout is designed toprovide you with the concise information about conditions, expectations and procedures by the physician and our staff.

**Appointments/Missed Appointments/Late Cancellations:**

We will make every effort to schedule an appointment within a reasonable time frame. Sometimes an appointment may take longer than planned or an emergency may arise. Every effort is made to stay on schedule.

- Patients arriving more than 15 minutes late for an appointment may be asked to reschedule.

- Broken appointments represent a cost to us, to you and to otherpatients who could have beenseen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments. Cancellations and no-shows for an appointment twice will be documented and may result in discharge from the practice.

- If we are unable to reach you due to disconnected phone numbers, your appointment may becanceled.

**Letters**

* If you request that we generate a letter on your behalf, your account will be charged $25. The fee is due when the letter is requested. This is not a covered insurance benefit and will be billed directly to the patient.

**Lost Items:**

* Should you misplace any items generated by this office theremay be a $15 charge for replacing them. This is not an insurance benefit and is due at the time of the request. This includes lost prescriptions, lab requisitions and physician orders for testing.

**Lab Reporting and Review:**

* Most labs will be done after your office visit. When a lab is ordered at a newpatient visit and**/**or consult, labs will be discussed at a face-to-face reports visit which is scheduled at the end of thefirst visit.
* If the lab is done between visits, it will be reported between 1-2 weeks after **it** is done. If you have not heard from us by phone concerning your lab by the end of the second week, please contact our office.
* Lab done by other physician's offices will not be reported without a scheduled visit with our office. If you would like us to **review** and interpret labs done elsewhere, please get copies of the lab and bring them with you **to** the visit. **WE WILL NOT BE RESPONSIBLE FOR OBTAINING LABs DONE AT OTHER OFFICES.** This is your responsibility. **We** discourage having labs faxed to us as it isour experience that labs or results that are supposed to be faxed are not sent to us 50% of the time which is why we require that you bring the lab results with **you**.

**\*\*\*** If your insurance requires you to go to a specific lab you must tell your provider at each visit \*\*\*

**Medication Refills**

* Refills will only be done at thetime of an office visit. It is your responsibility to keep up with medications and refills. This includes diabetes supplies and medications done on a 3 month basis.
* We will provide 30 and/or 90 day scripts at the time of the visit if you request refills.
* If your insurance changes and your scripts need to be re-written there will be a $10 to $15 charge.
* This is not a covered insurance benefit and will be due at the time ofpick up.
* We will not sign for generic substitutions between visits.
* All prescription functions must be taken care of at the time **of** your visit.

**Nurse Call Backs:**

* If you need to speak with the nurse and they are unavailable, you will be asked **to** leave a message.
* Messages left in the morning will be returned the same day.
* Messages left after 4:00 p.m. will be returned **the** following business day.
* In emergent situations, please speak directly with the receptionist, regardless of the time.

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Financial Policy Sheet**

To reduce confusion and misunderstanding between our patients and practice, wehave adopted the following financial policies. If you have any questions regarding these policies, please discuss them withour billing office at 877-835-8691. We are dedicated to providing the best possible care and service to **you** and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment..

Unless other arrangements have been made in advance by either you oryour health insurance carrier, full payment is due atthe time ofservice**.** For your convenience we accept cash, personal checks (in-stateonly) Visa, Mastercard American Express and Discover. There is a service charge **of** $25 for returned checks.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment priorto scheduling appointments. Werealize that financial difficulty is a reality. In such circumstances, we may advise you to seek your child's immunization through a clinic **or** health bureau.

**Your Insurance:**

Wehave made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for whichwe have an agreement and will only require you to pay the authorized co-payment/deductible at the time of service. This office's policy isto collect this copayment when you arrive for your appointment.

If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible for all charges billed, by you or by your Insurance carrier.

If you have insurance coverage with a plan for whichwe do not havea prior agreement, the charges for your care and treatment are due at the time of the service.

If you need assistance or have questions, please contact The Billing Coordinator between 8:30 a.m. and **4:30** p.m., Monday through Friday at **877-835-8691**.

**Minor Patients:** For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

**Refunds:**

Patients/guarantor credits in amounts less than $20.00 will be retained on account to be credited towards future balances unless a written request for refund is received. Amounts $20.00 and greater will automatically be refunded to the patient/guarantor.

**Managed Care**:

If you are enrolled in a managed care insurance plan (**i.e.,** HMO or Health Select Plan**)**, you must receive a referral from our office before seeing a specialist. Retroactive referrals are not guaranteed.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Printed Name of the Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Responsible party if a Minor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assignment of Benefits Form**

**Financial Responsibility:**

All professional services rendered are charged to thepatient and are due at the time of service, unless other arrangements have been made in advance with our billing office. Necessary forms will be completed to file for insurance carrier payments.

**Assignment of Benefits:**

I hereby assign all medical benefits, to include major medical benefits to whichI am entitled. I hereby authorize and direct my insurance carrier(s**)**, including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **North Star Family Medicine, P.A.** for medical services rendered to myself and/or mydependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

**Authorization to Release Information:**

I hereby authorize **North Star Family Medicine, P.A.** to:

1. Release any information necessary to insurance carriers regarding my illnesses and treatments.

2. Process insurance claims generated in thecourse ofexamination or treatment.

3. Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order

will remain in effect until revoked by me in writing.

I have requested medical services from **North Star Family Medicine, P.A. on** behalf of myself and/or my dependents and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation or the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card Authorization** Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled**.**

**Credit Card Information**

**Card** **Type**: **MasterCard VISA Discover AMEX Other**

**Cardholder Name (as shown on card): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**.

**Card Number:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Expiration Date** (**mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cardholder ZIP Code (from credit card billing address):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize NSFM/DR. DAYAL**to chargemy credit card

above foragreed upon purchases. I understand that my information will be saved to file for future transactions **on my account.**

Customer Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement of Review of Notice of Privacy Practices**

I have reviewed this office's notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy ofthis document.

Signature of Patient or Personal Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient or Personal Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Personal Representative's Authority\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list names and relationships of all persons NSFM is authorized to release medical information to.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**18 *years and* *older***

DATE:\_\_\_\_\_\_\_\_\_\_\_\_NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BIRTH DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AGE: \_\_\_\_\_\_\_\_\_\_\_M / F

**This** form **is for background** health **information.** It is part **of your medical records** and **is strictly** confidential**.** 2 PAGES TOTAL.

**Who Referred You? Previous physician:**

Past Medical History

Other doctors that you see? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please check all that apply to you:

Alcoholism \_\_\_\_ Heart Attack \_\_\_\_

Allergies/ Hay Fever \_\_\_\_ (Other Heart Trouble) \_\_\_\_

Anemia/ Bleeding \_\_\_\_ Hepatitis \_\_\_\_

Anorexia/ Bulimia \_\_\_\_ High Blood Pressure \_\_\_\_

Anxiety \_\_\_\_ High Cholesterol \_\_\_\_

Arthritis/ Gout \_\_\_\_ Kidney Disease \_\_\_\_

Asthma \_\_\_\_ Liver Disease \_\_\_\_

Birth Defects \_\_\_\_ Mental Illness \_\_\_\_

Blood Transfusion \_\_\_\_ Pelvic Problem (women) \_\_\_\_

Bowel Problems \_\_\_\_ Prostate Problem (men) \_\_\_\_

Cancer \_\_\_\_ Nerve Problem \_\_\_\_

Circulation Problem \_\_\_\_ Rheumatic Fever \_\_\_\_

Depression \_\_\_\_ Stroke \_\_\_\_

Diabetes \_\_\_\_ Tattoos \_\_\_\_

Emphysema/ COPD \_\_\_\_ Thyroid Problem \_\_\_\_

Epilepsy/ Seizures \_\_\_\_ Tuberculosis (TB) \_\_\_\_

Frequent Bladder Infections \_\_\_\_ Ulcers in the Stomach \_\_\_\_

GallStones \_\_\_\_ Venereal Disease/STDs \_\_\_\_

Glaucoma \_\_\_\_ Other Problems \_\_\_\_

Headaches \_\_\_\_ Type? :

**Health Maintenance**

**FEMALE: # of Pregnancies?\_\_\_\_\_\_\_\_\_\_ # of Children?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Pap Smear?\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mammogram?\_\_\_\_\_\_\_\_\_\_\_\_ Breast Exam?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bone Density Test?\_\_\_\_\_\_\_\_\_\_\_\_**

**MALE: Last Testicular Exam?\_\_\_\_\_\_\_\_ Prostrate Exam?\_\_\_\_\_\_\_\_\_\_\_ PSA Blood Test?\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALL: Last Blood Work:\_\_\_\_\_\_\_\_\_\_\_\_ Colonscopy/Flex Sig?\_\_\_\_\_\_\_\_ Chest X-ray:\_\_\_\_\_\_\_\_EKG?\_\_\_\_\_\_**

**Stress Test?\_\_\_\_\_\_\_\_\_\_\_\_ Eye Exam ?\_\_\_\_\_\_\_\_\_\_\_\_Hearing Test?\_\_\_\_\_\_\_\_\_\_Dental Visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have a LIVING WILL or ADVANCE DIRECTIVE?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Would you like info?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medications:**  (Please list all medications with dosage, that you take ***REGULARLY***. Include all pain-relievers, vitamins,supplements/herbs.)

**1. 2. 3. 4. 5.**

**6. 7. 8. 9. 10.**

**Allergies : (Please list any medication or food** allergies **and** the reactions **they cause you.)**

**1**.  **2. 3. 4. 5.**

**Surgical History: (Please list all surgeries with approximate dates**, **including C-sections.)**

**1. 2. 3. 4. 5.**

**6. 7. 8. 9. 10.**

**Immunizations When was your last**....

**Tetanus shot? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pneumonia vaccine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Flu vaccine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hepatitis B? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Others? (for travel, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family History (Please** fill **in your** family's **history, if known**.**)**

**Age Health problems Age** at **death Cause of death**

**Mother \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Father \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Brother/Sister** M/F \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

M/F \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

M/F \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

**Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Marital Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Hobbies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pets\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Children’s Names \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you smoke cigarettes?\_\_\_\_\_\_\_\_\_\_\_\_\_ Packs a day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_For how many years?\_\_\_\_\_\_\_\_\_\_\_\_\_When did you quit?\_\_\_\_\_\_**

**Do you smoke cigars?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you use snuff or chewing tobacco?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How many beers do you drink per week?\_\_\_\_\_\_\_\_\_\_\_\_Glasses of wine?\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other alcohol drinks?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How many cups of coffee per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tea?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Soda?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you use cocaine\_\_\_\_\_\_\_\_\_\_, marijuana\_\_\_\_\_\_\_\_\_, drugs injected into your veins\_\_\_\_\_\_\_\_, LSD (acid)\_\_\_\_\_\_or speed\_\_\_\_\_\_\_\_\_?**

**What** do **you do** for **exercise?**

**Review of Systems (Please circle all symptoms that are a problem for you.)**

**Const**  fever weight loss weight gain fatigue

**HEENT**  vision problem hearing problem dizziness nose problem hoarseness sore throat

**CV**  chest pain heart murmur palpitations/skipped beats leg cramps when walking

**Resp**  shortness of breath cough wheeze

**GI**  nausea/vomiting heart burn/reflux stomach pain constipation diarrhea blood in stool

**GU**  problems urinating incontinence erectile dysfunction blood in urine

**MS**  joint pain muscle pain swelling muscle cramps stiffness

**Skin**  skin problems hair problems nail problems

**Neuro**  headache numbness weakness seizures tremor

**Psych**  anxiety depression hallucinations

**Endo**  hot or cold intolerance year of menopause?

**Heme** bleeding problem easy bruising anemia

**Other**  please describe\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**:

**YOUR SIGNATURE PLEASE: DATE:**

***PEDIATRIC HEALTH HISTORY***

***Birth to 17 years old***

**DATE: NAME: BIRTH DATE: AGE: M F**

This form is for background health information about your child/ teen-ager and is strictly confidential. 1 PAGEs TOTAL.

**Who referred you? Previous Physician:**

**Birth and Past Medical History**

Pregnancy term: \_\_\_\_\_\_\_\_\_\_\_ Full or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_weeks. Delivery:\_\_\_\_\_\_\_\_\_\_\_\_\_Vaginal\_\_\_\_\_\_\_\_\_\_\_C-sxn

Birth weight: \_\_\_\_\_\_\_\_\_\_\_\_\_pounds, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ounces

Were there any problems during the pregnancy, labor, delivery, or first few weeks of life? **No Yes (please** describe**)**

**Any HOSPITALIZATIONS? No Yes** (please describe**)**

Please circle **ILLNESSES** that your child has had: **A**sthma Chickenpox Measles Mumps Frequent ear infections

Rubella Seizures Frequent tonsillitis Heart murmur Constipation Diarrhea Bladder/ Kidney infection

Other ?:

Please list all **MEDICATIONS** that your child takes ***REGULARLY.***

**1, 2. 3. 4.**

**Please** list any **medication ALLERGIES** or other allergies.

**1. 2. 3. 4.**

Please **list all SURGERIES your child has** had**.**

**1. 2. 3. 4.**

**Are IMMUNIZATIONS up to date? No** **Yes (Please bring their shot record to every visit.)**

**DEVELOPMENT: (**Please **indicate the age** your child first achieved **the following.)**

**Sat up \_\_\_\_\_ Stood \_\_\_\_\_ Walked \_\_\_\_\_ First tooth \_\_\_\_\_ Spoke** (single words) **\_\_\_\_\_\_ Formed** short sentences\_\_\_\_\_ **Toilet trained\_\_\_\_\_**

**Family History for your child/ teen-ager, if known**.

**Age Name Health Problems Age at Death**  **Cause of Death**

**Child's Mother \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child's Father \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child's** Brother**/Sister M/F \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**M/F \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**M/F \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please circle any other illnesses your family may have: diabetes high blood pressure high cholestrol heart disease stroke arthritis

kidney disease deafness cancer other ?:

Do you have concerns about his/her..... (please circle)

Bedwetting eating school performance concentration sleep speech drug use alcohol use

sexual education other ?:

**Parent**/**Caregiver signature please**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_